FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nursing & Rehabilitation Center

Address: 1314 Rowell Ave (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-5451 **Fax #** (815) 727-9413

HFS ID Number:

Date of Initial License for Current Owners: 8/31/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	230	Skilled (SNF)	230	83,950	1
2		Skilled Pediatric (SNF/PED)			2
3	36	Intermediate (ICF)	36	13,140	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,190	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,277	5,601	29,454	53,332	8
9	SNF/PED					9
10	ICF	2,628	175	7,558	10,361	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,905	5,776	37,012	63,693	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.15%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/31/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 230 and days of care provided 4,842

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Cente # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	545,886	69,193	26,864	641,943		641,943		641,943			1
2	Food Purchase		416,949		416,949		416,949	(1,779)	415,170			2
3	Housekeeping	424,025	67,564	60	491,649		491,649		491,649			3
4	Laundry	181,400	32,610		214,010		214,010		214,010			4
5	Heat and Other Utilities			364,881	364,881		364,881		364,881			5
6	Maintenance	209,879	31,299	213,142	454,320		454,320	(32,290)	422,030			6
7	Other (specify):*											7
8	TOTAL General Services	1,361,190	617,615	604,947	2,583,752		2,583,752	(34,069)	2,549,683			8
	B. Health Care and Programs											
9	Medical Director			99,500	99,500		99,500	(15,500)	84,000			9
10	Nursing and Medical Records	5,098,730	96,230	747,289	5,942,249		5,942,249	(4,785)	5,937,464			10
10a	Therapy	176,439			176,439		176,439	(2,153)	174,286			10a
11	Activities	171,335	13,916		185,251		185,251		185,251			11
12	Social Services	146,349		12,474	158,823		158,823	723	159,546			12
13	CNA Training											13
14	Program Transportation			469	469		469		469			14
15	Other (specify):*							153	153			15
16	TOTAL Health Care and Programs	5,592,853	110,146	859,732	6,562,731		6,562,731	(21,562)	6,541,169			16
	C. General Administration											
17	Administrative	230,345		80,000	310,345		310,345	20,802	331,147			17
18	Directors Fees											18
19	Professional Services			203,546	203,546		203,546	(13,953)	189,593			19
20	Dues, Fees, Subscriptions & Promotions			105,977	105,977		105,977	(30,624)	75,353			20
21	Clerical & General Office Expenses	510,164	44,443	399,061	953,668		953,668	(11,613)	942,055			21
22	Employee Benefits & Payroll Taxes			1,438,665	1,438,665		1,438,665		1,438,665			22
23	Inservice Training & Education											23
24	Travel and Seminar							369	369			24
25	Other Admin. Staff Transportation			31,171	31,171		31,171	(3,910)	27,261			25
26	Insurance-Prop.Liab.Malpractice			381,416	381,416		381,416	25,760	407,176			26
27	Other (specify):*							34,728	34,728			27
28	TOTAL General Administration	740,509	44,443	2,639,836	3,424,788		3,424,788	21,559	3,446,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,694,552	772,204	4,104,515	12,571,271		12,571,271	(34,072)	12,537,199			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center #0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			577,344	577,344		577,344	50,895	628,239			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,798	26,798		26,798	475,951	502,749			32
33	Real Estate Taxes							155,291	155,291			33
34	Rent-Facility & Grounds			1,449,421	1,449,421		1,449,421	(1,411,034)	38,387			34
35	Rent-Equipment & Vehicles			50,893	50,893		50,893	(18,556)	32,337			35
36	Other (specify):*							107,164	107,164			36
37	**TOTAL Ownership**			2,104,456	2,104,456		2,104,456	(640,289)	1,464,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	638,053	813,959	759,708	2,211,720		2,211,720		2,211,720			39
40	Barber and Beauty Shops			505	505		505		505			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			499,777	499,777		499,777		499,777			42
43	Other (specify):*	166,225		268,598	434,823		434,823	(434,823)				43
44	**TOTAL Special Cost Centers**	804,278	813,959	1,528,588	3,146,825		3,146,825	(434,823)	2,712,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,498,830	1,586,163	7,737,559	17,822,552		17,822,552	(1,109,184)	16,713,368			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(31,930)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(154,974)	30		9
10	Interest and Other Investment Income	(41,433)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(378)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(140,778)	21		18
19	Entertainment				19
20	Contributions		20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,466)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(925)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(659,709)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,039,593)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(69,592)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (69,592)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,109,185)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Salem Village Nursing & Rehabilitation Center

ID# 0044057

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Resident Lost Items	$ (1,021)	10	1
2	Marketing Salaries	(166,225)	43	2
3	Med A Budget Sequestration	(47,078)	21	3
4	Bank Service Charges	(16,545)	21	4
5	Collection Fees/ Cc Fees	(8,136)	21	5
6	Entertainment - Meals	(3,919)	21	6
7	Capitalized R&M	(21,132)	06	7
8	Bldg Co - Amortization	(4,344)	36	8
9	RFMS Petty Cash Clearing Acct	(1,310)	21	9
10	Medical Records Income	(3,749)	10	10
11	Rental Income	(225)	06	11
12	Miscellaneous Income	(2,501)	21	12
13	Misc Income - Red light ticket refund	(204)	21	13
14	Misc Income - Returned positive pay	(7)	21	14
15	Misc Income - Admin Salary	(720)	21	15
16	Misc Income - Benefit payment	(639)	21	16
17	Misc Income - IIT Rebate	(3,110)	21	17
18	Misc Income - Jury Duty	(15)	10	18
19	Misc Income - Meal Money	(1,401)	02	19
20	Misc Income - Select rehab	(2,153)	10A	20
21	Misc Income - US Legal	(169)	21	21
22	Misc Income - Settlement Stericycle	(4,677)	06	22
23	Misc Income - Class Action Settlement	(41)	21	23
24	PAC Dues	(22,204)	20	24
25	Non-allowable Legal	(1,783)	19	25
26	Additional R&M	11,759	06	26
27	Dividend Income	(5,160)	32	27
28	Marketing	(598)	43	28
29	Non-allowable Travel	(9,495)	25	29
30	Medical Director	(15,500)	09	30
31	Professional Fees	(15,000)	19	31
32	Non-allowable Expenses	(268,000)	43	32
33	Non-allowable Auto Lease	(28,675)	35	33
34	Collections	(12,000)	21	34
35	Non-allowable Interest	(3,731)	32	35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(659,709)		49

Salem Village Nursing & Rehabilitation Center

ID# 0044057

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,779)											(1,779)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(46,205)		13,915									(32,290)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(47,984)		13,915									(34,069)	8
	B. Health Care and Programs													
9	Medical Director	(15,500)											(15,500)	9
10	Nursing and Medical Records	(4,785)											(4,785)	10
10a	Therapy	(2,153)											(2,153)	10a
11	Activities													11
12	Social Services			723									723	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			153									153	15
16	**TOTAL Health Care and Programs**	(22,438)		876									(21,562)	16
	C. General Administration													
17	Administrative			20,802									20,802	17
18	Directors Fees													18
19	Professional Services	(16,783)		2,830									(13,953)	19
20	Fees, Subscriptions & Promotions	(31,670)		1,046									(30,624)	20
21	Clerical & General Office Expenses	(238,083)		226,470									(11,613)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			369									369	24
25	Other Admin. Staff Transportation	(9,495)		5,585									(3,910)	25
26	Insurance-Prop.Liab.Malpractice		22,341	3,419									25,760	26
27	Other (specify):*			34,728									34,728	27
28	**TOTAL General Administration**	(296,031)	22,341	295,249									21,559	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(366,453)	22,341	310,040									(34,072)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(154,974)	205,674	195									50,895	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(50,324)	524,138	2,137									475,951	32
33	Real Estate Taxes		155,291										155,291	33
34	Rent-Facility & Grounds		(1,441,634)	30,600									(1,411,034)	34
35	Rent-Equipment & Vehicles	(28,675)		10,119									(18,556)	35
36	Other (specify):*	(4,344)	111,508										107,164	36
37	TOTAL Ownership	(238,317)	(445,023)	43,051									(640,289)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(434,823)											(434,823)	43
44	TOTAL Special Cost Centers	(434,823)											(434,823)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,039,593)	(422,682)	353,091									(1,109,184)	45

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,441,634	Salem Village Property, LLC		$	$ (1,441,634)	1
2	V	32	Interest	494	Salem Village Property, LLC			(494)	2
3	V	32	Mortgage Interest Expense		Salem Village Property, LLC		524,632	524,632	3
4	V	30	Depreciation		Salem Village Property, LLC		205,674	205,674	4
5	V	36	Amortization		Salem Village Property, LLC		4,344	4,344	5
6	V	33	R/E Tax Expense		Salem Village Property, LLC		155,291	155,291	6
7	V	36	MIP Expense		Salem Village Property, LLC		107,164	107,164	7
8	V	26	Property Insurance		Salem Village Property, LLC		22,341	22,341	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,442,128			$ 1,019,446	$ * (422,682)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE	$	HEALTHCARE ACCOUNTING SERVICES, LLC		$ 13,915	$ 13,915	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC		8,722	8,722	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC		1,046	1,046	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC		2,950	2,950	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC		369	369	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC		5,585	5,585	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC		3,419	3,419	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC		195	195	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC		2,137	2,137	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC		30,600	30,600	24
25	V	35	AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		7,610	7,610	25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		2,509	2,509	26
27	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		144,793	144,793	27
28	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		20,067	20,067	28
29	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		20,802	20,802	29
30	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		1,955	1,955	30
31	V								31
32	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		78,727	78,727	32
33	V	27	EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		12,706	12,706	33
34	V								34
35	V	12	SOCIAL SERVICE		HEALTHCARE ACCOUNTING SERVICES, LLC		723	723	35
36	V	15	HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC		153	153	36
37	V								37
38	V	19	BOOKEEPING SERVICES	5,892				(5,892)	38
39	Total			$ 5,892			$ 358,983	$ * 353,091	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Office Space	$ 36,100	MS HEALTHCARE ACCOUNTING		$ 36,100	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,100			$ 36,100	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUMULATION TRUST	5.00%	CORI MANOR	ST. LOUIS MO.	SALEM VILLAGE PROPERTIES,	JOLIET	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION TRUST	5.00%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE	HEALTHCARE ACCOUNTING SE	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	KATHRYN VALES ACCUMULATION TRUST	5.00%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO	ACCOUNTING	3
4	KIMBERLY RICHMAN ACCUMULATION TRUST	5.00%	NORTHVIEW VILLAGE	ST. LOUIS MO.				4
5	MAKHLOUF & LORRAINE SUISSA	45.00%	EDWARDSVILLE CARE CENTER	EDWARDSVILLE				5
6	MELISSA ROTHNER ACCUMULATION TRUST	5.00%	UNIVERSITY CARE CENTER	EDWARDSVILLE				6
7	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	10.00%						7
8	RACHEL ROTHNER ACCUMULATION TRUST	5.00%						8
9	SHOSHANA ARYEH	10.00%						9
10	WILLIAM ROTHNER ACCUMULATION TRUST	5.00%						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Salem Village Nursing & Rehabilitation Cen # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Suissa	Owner	Administrative	45.00%	See Attached	12.48	20.80%	Alloc Fees/Sal	$ 100,802	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	N/A	N/A	40	100.00%	Salary	77,654	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 178,456		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE ACCOUNTING SERVICES, LL
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ILL, & MO. PAT. DAYS	306,193	7	$ 66,895	$	63,693	$ 13,915	1
2	19	PROFESSIONAL FEES	ILL, & MO. PAT. DAYS	306,193	7	41,928		63,693	8,722	2
3	20	DUES, SUBSCRIPTIONS	ILL, & MO. PAT. DAYS	306,193	7	5,030		63,693	1,046	3
4	21	CLERICAL & GENERAL	ILL, & MO. PAT. DAYS	306,193	7	14,180		63,693	2,950	4
5	24	SEMINAR	ILL, & MO. PAT. DAYS	306,193	7	1,773		63,693	369	5
6	25	TRAVEL	ILL, & MO. PAT. DAYS	306,193	7	26,851		63,693	5,585	6
7	26	INSURANCE	ILL, & MO. PAT. DAYS	306,193	7	16,437		63,693	3,419	7
8	30	DEPRECIATION	ILL, & MO. PAT. DAYS	306,193	7	937		63,693	195	8
9	32	INTEREST	ILL, & MO. PAT. DAYS	306,193	7	10,275		63,693	2,137	9
10	34	OFFICE SPACE	ILL, & MO. PAT. DAYS	306,193	7	147,104		63,693	30,600	10
11	35	AUTO RENTAL	ILL, & MO. PAT. DAYS	306,193	7	36,585		63,693	7,610	11
12	35	EQUIPMENT RENTAL	ILL, & MO. PAT. DAYS	306,193	7	12,062		63,693	2,509	12
13	21	CLERICAL SALARIES	ILL, & MO. PAT. DAYS	306,193	7	696,067	696,067	63,693	144,793	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, & MO. PAT. DAYS	306,193	7	96,469		63,693	20,067	14
15	17	ADMIN. SALARY - M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	100,000	100,000	63,693	20,802	15
16	27	EMP. BEN.-M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	9,398		63,693	1,955	16
17										17
18	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	139,325	4	172,211	172,211	63,693	78,727	18
19	27	EMPLOYEE BEN. GEN. & ADMI	ILLINOIS PAT. DAYS	139,325	4	27,794		63,693	12,706	19
20										20
21	12	SOCIAL SERVICE	SPECIFIC FACIL. DAYS	306,193	7	3,474	3,474	63,693	723	21
22	15	HEALTH CARE EMPLOYEE BE	SPECIFIC FACIL. DAYS	306,193	7	737		63,693	153	22
23										23
24										24
25	TOTALS					$ 1,486,207	$ 971,752		$ 358,983	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MS HEALTHCARE ACCOUNTING
Street Address: 3535 WEST GLENLAKE
City / State / Zip Code: CHICAGO, IL 60659
Phone Number: (917) 744-8688
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	OFFICE SPACE				$	$		$ 36,100	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 36,100	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Salem Village Nursing & Rehabilitation Cente # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Midwest Bank		X	Mortgage			$	$ 16,410,495			$ 524,632	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Select Rehabilitation		X	Note Payable				140,000				6
7	Advantage Leasing		X	Note Payable	$1,006.44	5/1/17	28,522	12,676	5/31/2020		2,570	7
8	See Supplemental Schedule										20,498	8
9	TOTAL Facility Related				$1,006.44		$ 28,522	$ 16,563,171			$ 547,699	9
	B. Non-Facility Related*											
10	Interest Income		X								(41,433)	10
11	Interest Income - Bldg. Co.		X								(494)	11
12	Allocated from HAS		X								2,137	12
13	Dividend Income		X								(5,160)	13
14	TOTAL Non-Facility Related						$	$			$ (44,950)	14
15	TOTALS (line 9+line14)						$ 28,522	$ 16,563,171			$ 502,749	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 107,164 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 179,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 164,291	2
3. Under or (over) accrual (line 2 minus line 1).		$ (14,709)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 170,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 155,291	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	165,694	8
	2014	176,632	9
	2015	176,501	10
	2016	170,946	11
	2017	164,291	12

2018 Accrual = $164,291 x 1.03 = $170,000 (rounded)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing & Rehabilitation Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-23-304-011-0000	Long Term Care Property	$ 163,267.46	$ 163,267.46
2.	30-07-23-304-007-0000	Long Term Care Property	$ 234.38	$ 234.38
3.	30-07-23-304-010-0000	Long Term Care Property	$ 789.18	$ 789.18
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 164,291.02	$ 164,291.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing & Rehabilitation Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	272		1998	1976	$ 8,021,280	$ 205,674	35	$ 267,376	$ 61,702	$ 8,021,280	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	4,306	4,306	108,512	9
10	Various			1999	240,599		20	11,861	11,861	230,590	10
11	Various			2000	193,202		20	9,097	9,097	180,750	11
12	Various			2001	97,999		20	4,691	4,691	86,820	12
13	Various			2002	88,413		20	46	46	88,237	13
14	Various			2003	45,533		20	189	189	45,533	14
15	Various			2004	113,429		20	734	734	110,244	15
16	Various			2005	141,586		20	1,843	1,843	130,782	16
17	Various			2006	207,633		20	1,418	1,418	197,904	17
18	Various			2007	18,325		20	995	995	15,997	18
19	Various			2008	92,767		20	(90)	(90)	91,465	19
20	Various			2009	72,176		20	4,194	4,194	61,002	20
21	Various			2010	276,388		20	17,408	17,408	241,542	21
22	Various			2011	311,964		20	26,604	26,604	234,697	22
23	Various			2012	362,518		20	30,724	30,724	205,873	23
24	Various			2013	406,638		20	34,306	34,306	244,621	24
25	Various			2014	155,227		20	12,888	12,888	57,573	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			577,344			(577,344)		69
70	TOTAL (lines 4 thru 69)		$ 10,954,192	$ 783,018		$ 428,590	$ (354,428)	$ 10,353,422	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,954,192	$ 783,018		$ 428,590	$ (354,428)	$ 10,353,422	1
2	Light Fixtures	2015	5,073		20	507	507	1,860	2
3	Remove Old And Install New Door /Frame	2015	3,154		20	315	315	1,078	3
4	Install Stoves, Exterior Lights And Panels	2015	8,238		20	824	824	2,677	4
5	Elevator Motor And Pump	2015	8,972		20	897	897	2,841	5
6	Rerouting & Rewiring Conduit 8 Rooms	2015	12,525		20	1,253	1,253	3,862	6
7	Entry Door On Dock Entrance	2015	2,721		20	272	272	907	7
8	Installed And Finished Dock Door Interior	2015	3,445		20	172	172	560	8
9	3Rd Floor Complete Circuit	2016	6,750		20	675	675	2,025	9
10	5 A/C Wall Units	2016	3,419		20	342	342	997	10
11	Nurse Call Station	2016	5,355		20	1,071	1,071	3,035	11
12	Air Conditioner With Heat Pump X5	2016	3,459		20	692	692	1,845	12
13	Compressor	2016	2,665		20	533	533	1,421	13
14	Generator Engine	2016	3,459		20	692	692	1,845	14
15	Electrical Upgrade	2016	4,463		20	446	446	1,190	15
16	4 Heating/Cooling Units	2016	2,773		20	555	555	1,433	16
17	Elevators Electrical Upgrades	2016	7,725		20	773	773	1,931	17
18	New Compressor For Dining Room A/C Unit	2016	5,578		20	1,116	1,116	2,696	18
19	Compressor For Lobby A/C Unit	2016	3,128		20	626	626	1,512	19
20	12.5 Ton Air Unit	2016	18,400		20	1,840	1,840	4,293	20
21	5 Ptech A/C Wall Units	2016	3,426		20	685	685	1,542	21
22	Aluminium Retainer And Caps	2016	4,156		20	416	416	935	22
23	Installation Of 9" Pit Ladder To Elevators	2016	12,471		20	1,247	1,247	2,598	23
24	Water Heater Replacement	2016	6,804		20	680	680	1,418	24
25	12 Ptech Units With Heat Pumps	2016	7,769		20	1,554	1,554	3,237	25
26	New Windows	2016	5,075		20	508	508	1,353	26
27	Under Lav Protectors	2016	4,802		20	240	240	580	27
28	Install Soft Start Model Line Starter	2016	2,950		20	148	148	307	28
29	New Water Heater	2017	6,891		20	345	345	660	29
30	A/C Unit	2017	3,426		20	171	171	300	30
31	Cable Lines To Resident Rooms	2017	16,439		20	822	822	1,370	31
32	A/C Unit	2017	3,591		20	180	180	299	32
33	Installation Of New Nurses Station 50% Down	2017	17,148		20	857	857	1,358	33
34	TOTAL (lines 1 thru 33)		$ 11,160,442	$ 783,018		$ 450,044	$ (332,974)	$ 10,407,387	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,160,442	$ 783,018		$ 450,044	$ (332,974)	$ 10,407,387	1
2	Electrical Rewiring Of Main Feeders - Mechanical Closet	2017	3,450		20	173	173	273	2
3	Humidifier Auto Control X 6	2017	4,781		20	239	239	379	3
4	Humidifier Auto Control X 6	2017	5,534		20	277	277	438	4
5	Ac Units	2017	4,116		20	206	206	309	5
6	New Nurses Station	2017	5,304		20	265	265	376	6
7	Upgrade Interior Of 4 Elevators	2017	39,045		20	1,952	1,952	2,766	7
8	Blower Assembly And Installation	2017	2,979		20	149	149	174	8
9	A/C Unit	2017	3,571		20	179	179	208	9
10	Fire Alarm	2017	2,619		20	131	131	153	10
11	Replaced Hydraulic Cylinder, Cleaned Down Elevator Pits	2017	10,380		20	519	519	562	11
12	Back Flow Repair Grounds Water Sprinkler	2017	3,049		20	152	152	254	12
13	Fixed Main Water Pipe, Replaced Fire & Jockey Pump	2017	3,705		20	185	185	232	13
14	Installed Ac Units	2018	9,050		20	453	453	453	14
15	Ceiling Panels	2018	3,518		20	176	176	176	15
16	Installed Xp Card And Frm Modules To Fire Alarm System	2018	2,754		20	138	138	138	16
17	Elevator Repair - Replaced Roller Assembly, & Lower Guide	2018	3,446		20	172	172	172	17
18	Basement Air Handler Electric Heater Repair	2018	4,213		20	211	211	211	18
19	Hot Water Mixing Repair	2018	4,949		20	247	247	247	19
20	Remove & Replace Cast Iron Mop Basin, Patched Floor	2018	2,920		20	146	146	146	20
21	Repaired Kitchen Waste Line & Installed New Clean Out	2018	2,850		20	143	143	143	21
22	A, B, C Wings, Recreation Area, Nurses Station, Dining,	2018	174,138		20	8,707	8,707	8,707	22
23	Kitchen, Conference Room, Resident Rms, Therapy Rms:	2018			20				23
24	Flooring, Millwork, Handrails/Bumper Guards, Cove Base,	2018			20				24
25	Lighting	2018			20				25
26	Electrical/Lighting, Flooring, & Wall Surfaces	2018	100,874		20	5,044	5,044	5,044	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,557,687	$ 783,018		$ 469,907	$ (313,111)	$ 10,428,947	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,557,687	$ 783,018		$ 469,907	$ (313,111)	$ 10,428,947	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,557,687	$ 783,018		$ 469,907	$ (313,111)	$ 10,428,947	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,557,687	$ 783,018		$ 469,907	$ (313,111)	$ 10,428,947	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,557,687	$ 783,018		$ 469,907	$ (313,111)	$ 10,428,947	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 963,846	$ 195	$ 142,248	$ 142,053	10	$ 736,262	71
72	Current Year Purchases	33,025		16,084	16,084	10	32,168	72
73	Fully Depreciated Assets	2,144,901				10	2,144,901	73
74								74
75	TOTALS	$ 3,141,772	$ 195	$ 158,332	$ 158,137		$ 2,913,331	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2011 LEXUS LS 460	2011	$ 30,000	$	$	$	5	$ 30,000	76
77										77
78										78
79										79
80	TOTALS			$ 30,000	$	$	$		$ 30,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,137,459	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 783,213	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 628,239	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (154,974)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,372,278	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2011 Lexus LS 460 - 2011	$ 39,141	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 39,141	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Rent - Storage				2,287			5
6	Allocated from HAS/MS HAS				36,100			6
7	TOTAL				$ 38,387 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 16,555 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Passenger Van	$	$ 8,172	17
18					18
19	Allocated from HAS			7,610	19
20					20
21	TOTAL		$	$ 15,782	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 281,875	$		$ 281,875	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			109,578			109,578	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			351,034			351,034	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				316,376		316,376	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			638,053		17,221	497,583		1,152,857	13
14	TOTAL			$ 638,053		$ 759,708	$ 813,959		$ 2,211,720	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,137	$ 33,024	1
2	Cash-Patient Deposits	45,727	45,727	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,293,284	5,293,284	3
4	Supply Inventory (priced at)	61,243	61,243	4
5	Short-Term Investments			5
6	Prepaid Insurance	67,110	70,687	6
7	Other Prepaid Expenses	101,694	9,465	7
8	Accounts Receivable (owners or related parties)	2,046,630	2,254,039	8
9	Other(specify): See Attached Schedule	275,948	1,088,049	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,904,773	$ 8,855,518	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cost	3,209,052	3,209,052	15
16	Equipment, at Historical Cost	2,733,987	3,549,987	16
17	Accumulated Depreciation (book methods)	(5,045,602)	(10,043,638)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	55,760	199,493	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 953,197	$ 5,344,174	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,857,970	$ 14,199,692	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,681,631	$ 4,238,965	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,227	44,227	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	872,375	872,375	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,158	50,158	31
32	Accrued Real Estate Taxes(Sch.IX-B)		170,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	758,634	798,634	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,407,025	$ 6,174,359	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	152,676	152,676	39
40	Mortgage Payable		16,410,495	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	5,587,180	2,847,368	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,739,856	$ 19,410,539	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,146,881	$ 25,584,898	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,288,911)	$ (11,385,206)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,857,970	$ 14,199,692	48

*(See instructions.)

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,810,675)	1	
2	Restatements (describe):		2	
3	**Prior Year Rent**	4,786,826	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 976,151	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,795,062)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(470,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,265,062)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,288,911)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Salem Village Nursing & Rehabilitation Center # 0044057 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,837,367	1
2	Discounts and Allowances for all Levels	(5,809,126)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,028,241	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,590,708	6
7	Oxygen	16,293	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,607,001	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	225	16
17	Sale of Drugs	242,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,350	19
20	Radiology and X-Ray	13,849	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 305,635	23
	D. Non-Operating Revenue		
24	Contributions	300	24
25	Interest and Other Investment Income***	41,433	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,733	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	44,880	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,027,490	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,583,752	31
32	Health Care	6,562,731	32
33	General Administration	3,424,788	33
	B. Capital Expense		
34	Ownership	2,104,456	34
	C. Ancillary Expense		
35	Special Cost Centers	2,647,048	35
36	Provider Participation Fee	499,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,822,552	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,795,062)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,795,062)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,828,262	44
45	Private Pay - Net Inpatient Revenue	1,276,544	45
46	Medicare - Net Inpatient Revenue	1,581,825	46
47	Other-(specify) Hospice	491,031	47
48	Other-(specify) Insurance	5,850,579	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,028,241	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,102	2,260	$ 120,587	$ 53.35	1
2	Assistant Director of Nursing	1,781	1,915	82,332	42.98	2
3	Registered Nurses	36,246	38,974	1,372,899	35.23	3
4	Licensed Practical Nurses	52,516	56,469	1,740,247	30.82	4
5	CNAs & Orderlies	97,330	104,656	1,713,068	16.37	5
6	CNA Trainees					6
7	Licensed Therapist	19,706	21,189	638,053	30.11	7
8	Rehab/Therapy Aides	10,100	10,861	176,439	16.25	8
9	Activity Director					9
10	Activity Assistants	12,513	13,455	171,335	12.73	10
11	Social Service Workers	7,960	8,559	146,349	17.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,184	38,908	545,886	14.03	15
16	Dishwashers					16
17	Maintenance Workers	11,713	12,595	209,879	16.66	17
18	Housekeepers	34,160	36,731	424,025	11.54	18
19	Laundry	14,052	15,110	181,400	12.01	19
20	Administrator	2,459	2,471	152,691	61.79	20
21	Assistant Administrator					21
22	Other Administrative	1,940	2,086	77,654	37.23	22
23	Office Manager					23
24	Clerical	26,526	28,522	510,164	17.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,921	3,140	46,410	14.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,120	5,505	189,412	34.41	33
34	TOTAL (lines 1 - 33)	375,329	403,406	$ 8,498,830 *	$ 21.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	509	$ 26,864	01-03	35
36	Medical Director	Monthly	99,500	09-03	36
37	Medical Records Consultant	Monthly	4,000	10-03	37
38	Nurse Consultant	351	14,040	10-03	38
39	Pharmacist Consultant	Per Chart	11,505	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	174	12,474	12-03	45
46	Other(specify)				46
47	Nurse Consulting	Monthly	34,356	03-10	47
48					48
49	TOTAL (lines 35 - 48)	1,034	$ 202,739		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	212	$ 11,823	10-03	50
51	Licensed Practical Nurses	660	27,149	10-03	51
52	Certified Nurse Assistants/Aides	5,561	644,416	10-03	52
53	TOTAL (lines 50 - 52)	6,432	$ 683,388		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Silver, Jomarie	Administrator	0	$ 130,142
Wilczak, Addison	Administrator	0	22,549
Suissa, Lorraine	Administrative	0	77,654
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 230,345

B. Administrative - Other

Description	Amount
Management Fees-Mark Suissa	$ 80,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 80,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 65,519
Marcum LLP	Accounting/Audit Fees	40,543
National Datacare Corporation	Data Processing	3,609
Paycom	Payroll Processing	59,549
Personnel Planners Inc	Unemployment Consulting	2,853
Healthcare Accounting Svcs.	Bookkeeping/Accounting	5,892
Achieve Accreditation LLC	Joint Commission Consulting	10,581
Husch Blackwell	Prior Period Expense (ADJ)	15,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 203,546

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 209,998
Unemployment Compensation Insurance	57,963
FICA Taxes	624,699
Employee Health Insurance	374,238
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer 401K Match/Pension	171,289
Employee - Holiday Expense	478
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,438,665

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	37,651
Health Care Worker Background Check	812
(Indicate # of checks performed 28)	
Patient Background Checks 197	2,555
Dues And Subscriptions	27,166
Licenses And Fees	2,143
Allocated from HAS	1,046
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,353

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from HAS	369
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 369

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $44,408**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,019** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **499,777**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees